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micromedia
a division of IHS Canada

20 Victoria Street
Toronto, Ontario M5C 2N8
Tel.: (416) 362-5211
Toll Free: 1-800-387-2689
Fax: (416) 362-6161
Email: info@micromedia.on.ca

PROVINCIAL GROUP ON LABORATORY REFORM

Facilitated by:
S. John Page and Barbara Kornovski

Submitted to the Ministry of Health and Long-Term Care

June 29, 2000

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I. Introduction

We were asked by the Ministry of Health and Long-Term Care (the "Ministry") to facilitate a process whereby the Ministry and representatives of three stakeholder organizations: the Ontario Medical Association ("OMA"), the Ontario Hospital Association ("OHA"), and the Ontario Association of Medical Laboratories ("OAML"), would meet over a period of five days to provide advice to the Ministry on issues relating to the reform and improvement of laboratory services in the Province of Ontario.

In this report, the OMA, OHA and OAML are collectively referred to as the "Stakeholders". The use of the term "Providers" includes hospital, community laboratories, and physicians in their role as providers of laboratory medicine services to patients in a region or regions.

The purpose of the facilitation process was expressly described by the Ministry in Terms of Reference setting up the consultation as follows:

> "... *the establishment of a time-limited, facilitated process with representation from key associations and the Ministry. This process aims to build on the current planning by the OAML, OHA and OMA, and feedback received following the closure of the RFPs in two regions of Ontario.*"

II. The Terms of Reference

The consultations were to be undertaken pursuant to specific Terms of Reference dated April 26, 2000 which were provided to the Stakeholders. A copy of the Terms of Reference is attached as Appendix 1.

The Terms of Reference were summarized for presentation at the Group's first meeting as follows:

Guiding Principles

I. Each region will have a laboratory services plan which:

- includes hospital and community lab services;
- ensures accessibility;
- limits duplication of operations and services;
- meets quality standards; and
- ensures an appropriate critical mass where testing is performed.

II. Funding systems will allow funding to follow service.

III. Consistent structures will be established in each region to oversee access to services and quality standards.

IV. Where testing can be centralized, it should occur in an orderly manner.

V. A laboratory physician and scientist human resource plan will be established to ensure availability of expert consulting and services.

VI. An accountability framework will be in place for each region to ensure consistent tracking and reporting of statistical and financial information.

VII. Contractual arrangements with obligations for quality and service delivery will be implemented for each service provider.

Objectives of the Process

I. Using the Guiding Principles, propose a process to develop a more:

- Co-ordinated

+

- Integrated

laboratory service plan.

II. Consensus on:

A. Structures

+

B. Processes

which are required in each region to ensure:

(i) Accountability

(ii) Access to and delivery of services

(iii) Appropriate ongoing planning

III. Proposed solutions must be:

A. Flexible to allow regions to customize services for unique needs of population within existing funding levels.

IV. Recommend

A. Order in which regional provincial implementation will roll out.

B. Mechanism for ensuring communication to all stakeholders and providers.

V. Alternative Objectives

A. If no consensus, on an alternative process

(i) advise on changes to RFP process before a new competitive process is initiated

A key point in the Terms of Reference is that certain topics were outside the subject matter of the Group's discussions as these matters are, or will be, planned and rolled-out in parallel to the laboratory reform and improvement process. These issues are:

- The development of the health information technology system; and
- The development of an enhanced quality management system.

III. The Facilitation Process

A. Our Report

The Terms of Reference required that we deliver a report setting out the outcome of the facilitation process. Our mandate also included obtaining feedback on the RFP process that had taken place in 1999 and reporting the Stakeholders' comments on how a competitive process could be improved.

Our report was initially prepared in draft, distributed to the Stakeholders for their feedback on whether the report accurately and completely reflects and records the discussions and outcomes of the discussion completed with them. After the Stakeholders' feedback had been obtained and incorporated by us, the report was finalized and circulated to the Stakeholders for their acknowledgement that the report accurately reflects the general agreement.

In addition to an acknowledgement from each of the Stakeholders that our report accurately reflects the general agreement reached during the consultations, the Stakeholders provided additional comments which could not be included as they did not form part of the consensus discussions. These comments are attached hereto as Appendix 2.

The report in its final form will be a public document. However, the various draft reports will not be made public.

B. Participants

The Ministry, Stakeholders and Facilitators are collectively referred to as "the Group" throughout our Report. A list of the persons who participated on behalf of each Stakeholder and the Ministry is attached as Appendix 3.

It was proposed by the Ministry in the Terms of Reference and agreed by the Group that each of the Stakeholders and the Ministry would have three representatives attend, as well as one resource person who would not participate in the discussions unless one of the representatives were absent for a session or a part thereof. It was also agreed by the Group that there would be no substitution of representatives.

C. Preliminary Consultations

As a preliminary step in this process, we met with representatives of each of the Stakeholders on an individual basis on May 3 and 4, 2000 to review process issues as well as to give each Stakeholder an opportunity to discuss with us their membership's core interests and concerns.

During these meetings, each of the OHA and OAML provided us with background information setting out their vision of laboratory reform in the Province of Ontario. In addition, the OHA provided us with several documents outlining various initiatives currently planned or underway across Ontario. These documents were of assistance to us in terms of understanding the view points of the Stakeholders and were also used for preparation of the second week's agenda and models.

D. Agendas

After the preliminary meetings with each of the Stakeholders and the Ministry, we prepared an agenda for the first week of meetings scheduled over May 10, 11 and 12, 2000. As discussed below, the agenda for the second week of meetings scheduled for May 18 and 19, 2000 was set by us after considering the outcomes from the meetings of May 10, 11, and 12 and consultation with the Ministry. The agenda for each week was provided to the Group in advance of the meetings.

E. Introductory Session

On the evening of May 10, 2000, the Group convened to hold an initial session to review the facilitation process, agree on ground rules and to allow each of the Stakeholders to communicate their core interests to the Group.

At the beginning of the introductory sessions, Assistant Deputy Minister for the Health Services Division, Mary Catherine Lindberg, gave brief introductory remarks and noted that it was desirable to build on the strengths of the existing system. She outlined why the Group was convened and what the Ministry hoped would be achieved through this process.

Following the presentation by Mary Catherine Lindberg, we went through a presentation on the proposed facilitation process and the ground rules.

Finally, each of the Stakeholders gave a short presentation of their core interests. A summary of these interests is set out in section III, below.

F. Consensus Building Sessions

The Group met on each of May 11, 12, 18 and 19, 2000 to work through the agenda items and to try to come to a general agreement on each matter of substance identified in the agendas. The issues on which general agreement was reached are discussed in Section IV below, those areas in which consensus was not reached are discussed in Section V below.

IV. Stakeholders' Core Interests

As noted above, the Group met for a preliminary session to allow each of the Stakeholders to communicate their core interests to the Group.

A summary of each Stakeholders core interests as they relate to the reform and improvement of laboratory services in Ontario is set out below.

A. OMA

The representatives of the OMA identified the following as their core interests:

- System reforms must preserve or improve the quality of patient care and the quality of service to physicians and patients, meaning the flow of timely, relevant clinical information and access to laboratory physician consultative services;

- Both clinical and laboratory physicians must be included and represented as stakeholders at all levels equal to the OHA, OAML and Ministry in discussions of laboratory reform;

- An open process is important to assist buy-in from medical stakeholders;

- The enhancement of competitiveness of laboratory medicine as a career choice for physicians, scientists and technologists in order to attract and retain medical laboratory professionals; and

- The creation of a system that ensures that resources for laboratory services, both human and monetary, are adequate and distributed appropriately throughout the province.

The representatives of the OMA also identified that arrangements between laboratories and laboratory physicians were critical to their core interest of enhancing competitiveness, therefore this item was added to the agenda for the second week's discussions.

B. OAML

The core interests, overall direction, plan, models for service and funding were presented in the OAML document provided to the Group. That document discusses:

- The roles of each provider must be identified and discussed;
- The corporate cap should be maintained during system transition;
- The need for population based funding;
- In the creation of a regional laboratory services plans, there must be a focus on efficiencies, but not in the context of a cost cutting exercise;
- There must be a mechanism to "dove-tail" the development of the information technology system to that of the regional laboratory services plans;
- Adequate consideration must be given in the planning process to meet future needs, especially in the development and implementation of new technologies;
- The regional laboratory services plans should not result in additional layers of bureaucracy;
- The economic value of the community laboratories who provide services throughout the whole province should be recognized;

- A proposal to build on the strengths of the current system;
- A call to the Ministry to identify the problems and possible gaps in services within the current system;
- The importance of information technology; and
- OAML should have equal footing with hospital laboratories for licensing of new tests and uninsured tests.

C. OHA

The members of the OHA identified the following as their core interests:

- The stability of hospital based laboratory services must be ensured so that hospitals are in a position to provide continuing quality services to physicians and patients;
- Any system that is developed for the improvement of laboratory services must be demonstrably better for patients and physicians;
- Laboratory services improvement should not be a cost-cutting exercise;
- Whatever new systems for the delivery of laboratory services are created, they must be flexible so that they can adapt to future needs;
- Work already done in the hospital sector to create new arrangements for the delivery of laboratory services should be built upon, rather than having a completely new model emerge;
- In order to plan accurately, base financial information from the hospital sector must be properly and accurately obtained; and

- The need to have on-site laboratory services in all acute care facilities in order to support clinical programs and physicians (e.g. ER, ICU, surgery, etc.).

V. Summary of General Agreement

The summary of the Stakeholders' general agreement is set out topically as follows.

Copies of the agenda for each of the sessions is attached as Appendix 4 and a copy of the document setting out certain models discussed during the course of the consultations is attached as Appendix 5.

1. *All providers will require representation in the planning process*

In order for the regional planning process to be effective and broadly based, the Stakeholders agreed that all providers in a region must be required to participate. In most cases, providers would be represented through representatives of their provider group. Stakeholders further agreed that providers who did not willingly participate in the regional planning process should be directed to do so by the Ministry.

2. *The Ministry's role in the regional planning process*

The Ministry's role in the regional planning process should be as follows:

> "... to supervise/facilitate planning and advise on the progress of planning, i.e. whether another mechanism may be required (such as a competitive process). If the region does not appear in the Ministry's view to be making progress to finalize a plan, the process will be discontinued and providers directed as to their roles in the region."

The Ministry's role should be an active one through representatives with sufficient seniority and laboratory expertise to ensure that the process is effective and sound plans are developed.

3. *Legislative and regulatory barriers should be removed by the Ministry of Health to aid the implementation of regional plans*

One of the key barriers to the improvement of the delivery of laboratory services in Ontario was identified as the inability of funds to flow between the sectors. The Stakeholders identified this barrier as the cause of some of the duplication which the Ministry hopes to reduce, if not eliminate, through the regional laboratory services plans. Other barriers include restrictions in what services laboratories can perform as a result of licensing regulations.

It was acknowledged that certain legislative barriers will have to be lifted in order for this principle to be put in practice and the Ministry committed to ensuring that this occur in line with the regional planning process and the development of plans.

4. *The "starting point" for regional service plans*

After lengthy discussion regarding each providers' existing role in providing services, the following points of general agreement emerged:

- The starting point for the creation of the regional plan should be the roles of the existing providers and the services offered by them.

- The regional planning process must identify gaps in services, service improvements, and other key service and quality issues and must ultimately result in a regional service plan which ensures that these issues are all dealt with for all services delivered under the plan.

- Existing service delivery models may change to best meet the defined service objectives of the regional plan.

5. ***Regional services plans should be developed by a Regional Steering Committee ("RSC")***

Regional laboratory services plans should be made by a Regional Steering Committee ("RSC") in each region, and after acceptance within each region, submitted to the Ministry for approval.

The RSC should be small, representative and reflect the types of providers in the region.

The Stakeholder (non-Ministry) membership on any RSC should not exceed seven persons based on a composition of two members from each of the medical profession and the community laboratory sector and up to three members from the hospital sector in order to allow for each of the types of hospitals in the region (e.g. academic health sciences centres, community hospitals, small and rural hospitals, etc.) to be represented on the RSC.

The role of the Stakeholder representatives will include obtaining information and feedback from interested parties, including but not limited to, patients, family physicians, long term care facilities and the District Health Councils ("DHCs").

The role of the DHC in the RSC should be restricted to that of an observer.

6. ***Regional plans should be rolled-out incrementally***

The Stakeholders agreed that the regional laboratory services plans should not be planned and implemented in all regions simultaneously, but rather that the plans should be rolled-out incrementally across the Province. The reasoning behind this decision is that some regions are further ahead of others in their plans to provide more coordinated laboratory services. All Stakeholders agreed that it would be best to build on current models and successes to ensure that the initial regional plans could follow the Ministry's timeline of planning commencing no later than the fall of 2000.

7. ***The three regions for the first phase of reform and improvement should be selected based on criteria to be determined by the Group***

The Stakeholders agreed that three identified regions could be rolled-out during the first phase of regional planning and service delivery. There was discussion, but no final decision, as to which of the regions should go first, second and third.

8. ***Draft criteria for the selection of the first three regions to begin the development of regional laboratory services plans***

The Stakeholders accepted that the Ministry use the following criteria to select the first three regions to prepare and implement a regional plan:

- Stakeholder readiness as indicated by the extent of their planning to date
  - considerable progress made in the development of joint service plans between hospitals
  - consolidation of hospital services as a result of HSRC directions
  - partnerships/joint ventures between private and public service providers

- Ease of implementation
  - progress in hospital planning for consolidation of services
  - state of planning between various providers

- Demonstrated ability of service providers to work together
  - history of cooperation between sectors
  - planned and established networks
  - number of champions in a region

- Communication
  - Ability of reform champions in the region to send a positive message on the benefits of change

9. ***Timing for planning milestones and completion***

Generally, a period of 5-6 months seemed to be a reasonable timeframe for the completion of the first three regional plans, subject to some adjustment based on the stage of plan development in a given region.

The OAML preferred planning to proceed as quickly as possible, but readily acknowledged the complex and time-consuming issues the hospitals would face in moving towards the creation of a regional plan. The OAML also indicated that they would require some flexibility in the timing given the fact that considerable resources will be required in each region and that some of those resources, primarily human resources, may overlap from region to region.

The OHA supported timely completion of each regional plan but emphasized that the success of the process would be greatly enhanced if time were built into the planning process to ensure a complete understanding and buy-in of key hospital groups including senior management, the medical advisory group and, most importantly, the board of directors.

The OMA was supportive of timely completion of the regional planning process but emphasized that timing must allow for consultation within and buy-in from the ultimate users of the system, physicians.

10. ***Proposed timelines of the development of regional plans over a six month period may be workable for the first three regions, but will have to be more flexible for the second and third phases***

In general, the following timeframes for defined milestones at 2, 4 and 5 month intervals were:

Within 2 months:

- Planning group established: sub-groups as required for the progress to date in the region.

- Baseline information confirmed, gaps or service problems that require special examination identified, review of services (Section 11 of the pilot RFPs list service components and elements for the regional plan; quality targets are in Schedule D of the RFP). Identify any barriers to achieving a regional plan. Review hospital allocations and services to identify whether additional review of any by Ministry financial staff is required.

- Identify any service expectations/ standards that may need to be revisited with the Ministry, based on the region's existing services.

Within 4 months:

- Identify service enhancements or efficiencies and plan for achieving service changes, and timelines.

- Prepare a laboratory physician/ scientist human resources plan.

- Principles for a human resources plan if plans call for staffing changes in any facility.

Within 5 months:

- Plan submitted to the Ministry for approval after circulation for acceptance.

- 3rd party assessment of plan to ensure plan provides best value (quality and efficiency) for money: Ministry to appoint.

These milestones are set to ensure that the Ministry has a mechanism to check the progress of each regional steering committee and to intervene, if necessary, should the planning process in any region reach a stalemate or any other impassable barrier.

The Stakeholders agreed that the timelines could be met in the first three regions as these will be selected, among other things, on the basis of how advanced they are in terms of the laboratory services planning process. However, the Stakeholders were clear that such timelines would likely be too tight for other regions and suggested that an eight month period such as a school year may be more workable.

There was discussion regarding when to commence preparation of the remaining regions, and in particular Toronto, for the roll out of the second and third phases. Given the fact that there must be a period of relationship building prior to the convening of the RSC for the purpose of developing the regional plan, the suggestion was made that this occur as early as possible in advance of the start date for the planning process in each region.

11. ***Regional services plans should be forward-thinking so that in the future it will be possible for funding to follow the patient.***

The Stakeholders agreed that the present funding and information exchange structures, as well as the legislative and regulatory framework do not allow for funding to follow the patient. It is the recommendation of the Stakeholders that each regional plan be developed with the intention that in the future funding will be able to follow the patient and that barriers to sound and workable plans will be removed.

Comments on Funding and Accountability

Before proceeding to summarize our conclusions regarding general agreement amongst the Stakeholders regarding funding and accountability, we believe it is important to put those conclusions in some context.

During our lengthy discussions with the Group, it became readily apparent to us that two key issues are at the heart of any reform of laboratory services in the Province: funding and accountability. Both the community laboratories and hospital representatives, (in our view, rightly so) see the appropriate resolution of these two issues as the key to successful reform within each of their operating sectors. To the credit of the constituents

of the community laboratory and hospital sectors who participated in this process, all recognized that the laboratory system in the Province requires significant change in the areas of both funding and accountability. How these changes are to be undertaken and over what period of time was the more pressing and serious concern for both community laboratory and hospital providers. On this point, we think it is appropriate to emphasize the following.

First, representatives of the OHA participating in this process expressed concern that the proposed reform and improvement of laboratory services be implemented, to the extent possible, on a voluntary rather than a mandatory basis. The process should encourage consultation and buy-in from individual hospitals. The buy-in should be based on a business-case presentation that the hospital being asked to buy-in will receive for its patients and user-groups better and more efficient laboratory services required to continue the existing level of medical care for its community. Hospital participants who are convinced at an operating and business level that the service models called for in a regional services plan are advantageous to their hospital will willingly support such changes, thereby making the process and end product reachable and acceptable.

Second, representatives of the OHA noted that regional service plans and the changes that will impact the hospital sector must respect the existing decision-making processes within hospitals, including the ultimate legal liability of the hospital board to be responsible for all aspects of the hospital's operations. Sound and compelling business and operational cases for the proposed changes should be presented to and understood by key hospital decision-makers, including its board members. With the presentation of such business and operational cases, it is very likely that hospital providers will move, over an appropriately agreed time-frame, to the adoption of funding and accountability structures which will most effectively allow laboratory services to be planned and delivered on a regional basis.

Thirdly, the OAML emphasized the importance that both hospital and community providers continue as the primary provider of the services each sector now provides.

Each sector has developed its own specialized expertise and efficiencies and an effective regional plan must capture these existing and unique advantages brought to the table by each sector. As well, the OAML emphasized that when service and access issues are settled to the satisfaction of the users of laboratory services and the Ministry, effective reform and improvement should incorporate a process to assess cost effectiveness of services delivered under regional plans.

12. *The creation of funding envelopes*

The Stakeholders agreed that, in general, funding envelopes should be developed by the Ministry which provided the ability for Stakeholders to transfer funds both intra and inter-sectorally where services have been so transferred. The starting point for funding is the existing allocation to hospitals and laboratories.

13. *The funding model*

Subject to our comments above, the Stakeholders agreed that funding for regional services plans would be best structured as follows:

- One provincial funding envelope consisting of current funding for community laboratories, current hospital global allocations for laboratory services and allocation for laboratory pilot projects currently underway.

- It must be recognized that the establishment of baseline funding in the hospital sector is a critical part of the proper calculation of amounts to be included in both provincial and regional funding envelopes.

- Initial funding should be not less than current levels, but a mechanism should exist to provide for change in funding allocation to meet such needs as intra and inter-sector service re-allocation and introduction of new technologies and programs.

- The Ministry will establish a regional envelope of total funding for the region initially based on existing expenditures with the acknowledgement that identifying and accounting for all expenditures for laboratory services will require additional detailed investigation.

- Based on the regional plan, and the specified role of each provider, the Ministry will determine the allocation.

- Payments will be made by the Ministry directly to providers based on contractual arrangements.

- Regional service plans could evolve to include mechanisms which allow the Ministry to make payments to groups of providers.

- The Provincial Advisory Group, consisting of representatives of the OHA, OMA and OAML would provide advice to the Ministry on funding issues and on general issues relating to the provision of consistent laboratory services in each region.

- Consistent with direct payment to providers, payment for physician services would be from a segregated pool. The intention is for physicians to have a choice of remuneration. APP-like arrangements, amongst others, could be discussed in the context of physician compensation agreements.

14. *Accountability amongst and between providers*

Once the regional laboratory services plan is submitted by the RSC, and approved by the Ministry, the Ministry will contract with providers to ensure that each is accountable for the services they have agreed to provide and also to ensure that there are no gaps in services in and between any regions in the province. Funding will be provided on the basis of these contractual arrangements.

During the transition period from the current system to the implementation of the regional laboratory services plans, contracting will continue with existing providers but may move to contracts between the Ministry and groups of providers as the regional plans are implemented.

15. ***Approval of regional laboratory services plans***

The planning of each regional laboratory services plan should be open and should, at a minimum, ensure that input and support is gathered from groups incrementally by members of the regional steering committees to encourage evolving support and buy-in during the course of plan development.

A final draft of each regional laboratory services plan should be circulated to the decision-making level of all community laboratories, physicians groups, senior management, medical advisory committees and hospital boards affected by the proposed regional plan for their review and input. Any issues raised in this final review should be reported back to the RSC and the Ministry for full consideration, particularly with regard to quality and service access issues that may be raised in the course of these reviews.

The Ministry will be the decision making authority on all regional plans.

16. ***A Provincial Advisory Group should be convened regularly***

The Stakeholders identified that a Provincial Advisory Group, constituted in a manner similar to the present Group, should be established and convened on a regular basis. The Provincial Advisory Group should advise the Ministry on all issues relating to the provincial laboratory services system.

As the function of the Provincial Advisory Group will be to provide advice to the Ministry and the industry on such matters as standards, it was agreed by the Stakeholders

that the group would function best if it were representative of providers and also if its numbers were kept small.

Representation from each of the Stakeholders should be similar to the composition of the Provincial Group on Laboratory Reform.

VI. Issues for Further Discussion

Although general agreement was reached on many key issues discussed above, the issues below were discussed but not resolved during the Group's meetings.

- which regions should go first, second and third;
- legislative and regulatory barriers to reform and improvement;
- the degree of governing power, if any, of the RSC and Provincial Advisory Group;
- the need to avoid the creation of additional layers of bureaucracy;
- the total costing of laboratory services within some hospitals is incomplete and will need to be addressed. Such information is critical to ensuring that the baseline funding accurately reflects current expenditures;
- the need to come to terms with the complexity and requirement for information sharing;
- the need for recognition of existing cost saving mechanisms and practices within hospitals and private laboratories; and
- capital funding was discussed, but no specific recommendations were put forward.

VII. The 1999 RFP process and other competitive processes

On May 19, 2000, the Stakeholders were asked to provide their feedback on the 1999 RFP process and to comment on how any future competitive processes could be improved. The consensus of the Stakeholders is set out below.

A facilitative process is preferable to a competitive one

Both the OAML & OHA stated that they do not consider the RFP process an acceptable mechanism for service planning. The Stakeholders indicated that a facilitated process, such as the one that is the subject of this report, is preferable to any competitive process such as an RFP. One of the key advantages of a facilitated process is the ability to communicate directly with the Ministry to obtain clarification of the desired outcomes from the Ministry.

Any future competitive process, should that be the mechanism employed by the Ministry, should contain provision for meaningful input from Stakeholders as a starting point. In addition, the guiding document for a competitive process should state clearly what the advantages of the reforms would be for all Stakeholders so that it is a win-win proposition in terms of providing access to quality services and efficiencies.

VIII. Conclusion

The constituents attending on behalf of Stakeholders were very co-operative in setting aside a large block of time over a compressed period of time in order to participate in the facilitation process. The quality of the comments and discussion illustrated a wise and practical understanding of the issues that the Ministry faces as it embarks on the complex process of laboratory services reform and improvement.

As a result of the commitment by the Group, general agreement was reached on a number of substantive issues which will allow the Ministry to move forward in its plans for the reform and improvement of laboratory services in the Province. If the Ministry receives, at the regional level, the level of thoughtful participation and commitment exhibited by the Stakeholders in this consultative process, the creation and implementation of efficient and effective regional laboratory services plans are in good hands.

Submitted by

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S. John Page

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Barbara Kornovski

Toronto, June 29, 2000.

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Appendix 1 -Terms of Reference April 26, 2000

PROVINCIAL GROUP ON LABORATORY REFORM
TERMS OF REFERENCE

BACKGROUND

For several years the Ministry of Health and Long-Term Care has dialogued and consulted with laboratory service providers in all sectors to identify laboratory service improvement needs and strategies for moving forward with laboratory system reforms. These discussions included a full review of the laboratory services system (between 1992 and 1994) and the issue of recommendations, the release of Planning Objectives for Laboratory Services Restructuring in 1996, and consultations on regional contracts for services in 1998. Communications from 1996 have clearly indicated the government's intention to establish laboratory services that are better co-ordinated, more responsive to unique regional needs. Reforms will include regional plans for service, reforms to funding systems along with improvements in quality management and information systems.

In January 1999, two pilot Requests for Proposals (RFPs) for integrated laboratory services were released in two regions of the province (in North and Central South Ontario). The process was closed mid-year, with no proposal meeting the mandatory requirements. Follow-up discussions with key stakeholders and Associations to solicit feedback on the RFP process and requirements were initiated in September 1999. Associations asked for time to work together to identify potential areas of common interest and co-operation, and to propose an alternative to the RFP process. However, provides have told us that a formal approach is required to move the process forward in a timely manner.

The Ministry of Health and Long-Term Care has been directed to move system reforms forward through the establishment of a time-limited, facilitated process with representation from key associations and the Ministry. This process aims to build n the current planning by the OAML, OHA and OMA, and feedback received following the closure of the RFPs in two regions of Ontario.

PROVINCIPAL GROUP

1.0 **Membership of the Provincial Group**

Key Associations (Ontario Hospital Association, Ontario Medical Association, Ontario Association of Medical Laboratories)	maximum 3 representatives (each)
Ministry of Health and Long-Term Care	maximum 3 representatives

2.0 **Guiding Principles**

The Provincial Group will be guided by the following principles:

- Each region will have a laboratory services plan, including hospital and community laboratory services, that ensures accessibility while limiting duplication of operations and services to what is required to meet quality standards and ensure an appropriate critical mass of testing where it is performed
- Regional service reforms will proceed in advance/in parallel to information system development
- The development of an enhanced quality management system will proceed through a separate process
- Funding systems will allow funding to follow services
- Consistent structures will be established in each region to oversee access to services and quality standards, including ensuring that were testing can be centralized, this occurs in an orderly manner
- A laboratory physician and scientist human resources plan will be established to ensure the availability of expert consultation and services
- An accountability framework will be in place in each region to ensure consistent tracking and reporting of statistical and financial information, in support of the government's accountability requirements
- Contractual arrangements with obligations for quality and service delivery will be implemented for each service provider

3.0 **Project**

- Propose an alternative process to the 1999 pilot RFPs for development of more co-ordinated, integrated laboratory services. If a consensus on an alternative cannot be achieved, advise on the changes to the prior RFP process that are indicated before initiating a new competitive process
- Reach consensus on the structures and processes required in each region to ensure accountability, appropriate ongoing planning, access to and delivery of services. Provincial Group solutions must be sufficiently flexible to allow regions to customize their services for the unique needs of their population, within existing funding levels
- Recommend the order in which regional provincial implementation of reforms will roll out
- Recommend a mechanism for ensuring communication to all stakeholders and providers
- The outcome of the Provincial Group's considerations will be included in a report to the MOHLTC, to be provided by the facilitator

4.0 **Timeframe**

The Provincial Group's recommendations are to be completed by the third week of May 2000.

April 26, 2000

Appendix 2 - Stakeholders' Additional Comments

OHA

The OHA provided the following additional comments:

- Add another bullet point that states: "All acute care hospitals require on site laboratory services to support clinical programs and physicians" to item 4 on page 14.
- Add the words "by the stakeholders" to the first bullet point under "within 5 months" in item 10, page 18.
- Replace the words "could be" with the word "may" in the first paragraph of page 19.
- Add "It is important to understand that hospitals will expect any savings derived from hospitals, as we undergo laboratory reform, to remain with the facilities and be reinvested in hospital operation." to the third paragraph on page 20.
- Delete the second paragraph on page 25.

OAML

The OAML provided the following additional comments:

- Add a statement that there was consensus that research and education would be segregated from global funding.
- Add the words "as drafted in the MOHLTC original terms of reference and distributed to stakeholders" to the title of item 2 on page 13.
- Add the word "community" between the words "services" and "laboratories" in the last sentence of the first paragraph under item 3 page 14.
- Replace the words "Regional planning process" with the words "The MOHLTC must help to identify and help other stakeholders to" in the second bullet of item 4 on page 14.
- Allow the OAML to have three members in the first sentence of the third paragraph under item 5 page 15.
- Add the phrase "and that the corporate cap should remain in place during this transitional period" to the end of the last sentence of the fifth paragraph under the heading "Comments on Funding and Accountability" page 21.
- Add the phrase "with one envelope with separate pools for hospitals and community laboratories" to the second sentence of item 12 page 22.
- Delete the second paragraph on page 25.

OMA

The OMA provided the following additional comments:

- Add the sentence "The Stakeholders acknowledge that the primary input for the Laboratory Physician/Scientist human resource plan should be from the incumbent providers of these services" after the series on bullets in item 10 page 18.

Appendix 3 - Constituents of the Provincial Group on Laboratory Reform

Organization	Members	Resource person
Ministry of Health and Long-Term Care	John King Mary Catherine Lindberg Dawn Ogram	David Mackey
Ontario Association of Medical Laboratories	Ken Kirsh Donald Kerr Cameron Crawford	Virginia Turner
Ontario Medical Association	Dr. Murray Treloar Dr. Greg Flynn Dr. Harry Richardson	Jim Simpson
Ontario Hospital Association	Rhonda Crocker-Blackwood Victor Simon Desmond Morrow	Robert Muir
Facilitators	S. John Page Barbara Kornovski	Conan McIntyre

Appendix 4 - Agendas for May 10, 11, 12,18 & 19, 2000

PROVINCIAL GROUP ON LABORATORY REFORM FACILITATION PROCESS

AGENDA

Wednesday, May 10, 2000 – 7:00 – 10:00 p.m. – Sutton Place Hotel – (Second Floor)

- Light supper available commencing at 6:30 p.m.

1. Introduction of participants
2. Ministry of Health and Long Term Care – Expectations and Requirements from The Facilitation Process
3. Review of process issues-By Facilitator
4. Review Statement of Principles-By Facilitator
5. Review Objectives of Consultations-By Facilitator
6. Statement of OHA, OAML and OMA – Defining the Core interests of each stakeholder

Thursday, May 11, 2000 - 9:00 a.m. – 12:30 p.m.

1. Creation, Operation, and Monitoring of Regional Plans

- Objectives
  - Ensure and continue accessibility to services without service gaps
  - No unnecessary duplication of services
  - Services meet defined quality standards
  - Ensure appropriate critical mass of service where it is performed
  - Appropriate ongoing planning
- What parties should be involved in creating, operating, and monitoring a regional plan
- Process to reach plan
  - Imposed by MOHLTC
  - Imposed by Independent 3rd party
  - Agreement between defined group of users/providers
- Role of each party

- Plan approvals/timelines
- Dispute resolution/conflict of interest

2. **What do stakeholders require the MOHLTC to do to stimulate and support the creation of a regional plan**

   - Role definition
   - Changes to legislative/regulatory environment

3. **What types of structures amongst existing providers do you think can be utilized to develop a regional plan and deliver services mandated by a regional plan to avoid gaps in services**

   - Community providers or hospitals alone
   - Community providers together
   - Hospitals together
   - Community providers and hospitals together
   - What structures/roles would work best for the various services
   - What are the enablers and structures for providers to operate together to deliver regional services

12:30 p.m. – 1:30 p.m. – Lunch Break

1:30 p.m. – 5:00 p.m.

4. **How do stakeholders propose that performance and accountability of providers be measured in a regional services plan**

   - Who will monitor and evaluate
   - What structures and processes should be used

     - contractual
     - funding
     - other
     - formal/informal provincial or regional processes

5. (a) What structures and processes do stakeholders suggest every region have to ensure province-wide consistency of service delivery

5. (b) What structures, processes, or service delivery options should be left to the discretion of the region

Friday, May 12, 2000 - 9:00 a.m. to 12:30 p.m.

6. What do stakeholders propose as an approach to funding at the regional level

- A single envelope or divided into sub-regions
- Direct payments to a sector
- Other funding structures or processes

7. How do stakeholders see gaps in services being avoided by regional funding

- Specific contracts with providers
- Other approaches – role definition

8. How do stakeholders view funding accountability

- What funding accountability measures should be in place for all service
- Contractual structures (eg.)
  - Multiparty contract with MOHLTC that includes cross-covenants between the providers
  - Separate contracts with service providers and with hospital clusters

9. How can the funding approach ensure an element of competition in each of the regions

10. In the stakeholders' view, what aspects of the current funding system should be eliminated in transition to a regional plan

12:30 p.m. – 1:30 p.m. – Lunch

1:30 p.m. – 5:00 p.m.

11. Transition to regional plans

- How should regional plans be implemented
  - sector by sector or all at once
  - region by region or province-wide
  - steps to be taken if province phases in implementation on a region by region basis

12. Communication to stakeholders and other parties impacted by a regional plan

- What should be communicated
- How

13. Identify issues for further discussion/resolution at continued meetings on May 18 and 19

Provincial Group on Laboratory Reform Facilitation Process

AGENDA

Thursday, May 18, 2000 – 9:00am –5:00pm and Friday, May 19, 2000 - 8:00am to 3:00 pm

Sutton Place, 2nd Floor

1. **Regional Steering Group**

General agreement on:
- **Small group representing providers, physicians/scientists/technologists, patients, and DHC**

To do:
Criteria for selection of members (Reference attached Draft Discussion Models)

Timing: ½ hour

2. **Regional Planning:**

General agreement on:
- All providers in region required to participate
- The MOHLTC to select the first regions to proceed in roll out based on criteria
- Plans completed and submitted within 5-6 months

- Defined milestones to be completed within 2 and 4 month timeframes to indicate progress

To do:
- **Define role of MOHLTC in planning**
- Review MOHLTC expectations on timing
- Define criteria for first regions/ roll out
  (Reference attached Draft Discussion Model)
- Consider timing for balance of regions

Timing: 1 ½ hours

3. **Accountability and Funding Models**

General Agreement on:
- Approach to physician funding : may include APP contracts
- One funding envelop per region
- Service delivery may shift from one sector to another with the movement of equivalent funds
- Starting point to be existing service providers and allocation, which may change after regional plans are developed (based on service improvements, quality, efficiencies, etc).

To do:
- Secure agreement on the most appropriate models(s) for funding and governance (Reference attached Draft Discussion Models)
- Secure agreement on accountability mechanisms: contractual arrangements, based on the draft discussion models
- Secure agreement on review/ approval route of plans before submission to the MOHLTC for approval

Timing: 3 hours

4. **Provincial Group:**
(Reference attached Draft Discussion Models)

General Agreement on:
- Need for a Provincial Advisory Body
- Group to advise on general issues as well as regional planning issues

To do:
- Advise on composition, structure, major areas of focus (including funding review and negotiation)

Timing: 1 hour

5. **Communications**

General agreement on:
- Need for a strategy for informing all providers of lab reform roll out

To do:
- Provide advice on the mechanisms that are likely to prove most effective when communicating reforms to providers

Timing: To be determined

6. **If no agreement on the process for collaborative planning for regional service plans:**

To do:
- Advise on changes to the 1999 RFP process in order to prepare for a competitive process in each region

Timing: To be determined

Appendix 5 - Provincial Group on Laboratory Reform Facilitation Process – Draft Discussion Models: Regional Plans – May 15, 2000

CONFIDENTIAL: FOR DISCUSSION PURPOSES ONLY

Provincial Group on Laboratory Reform
Draft Discussion Models: Regional Plans
May 15, 2000

Regional Planning Process:

1. Each region organized by groups of providers (hospital networks) and groups of community laboratory providers.

2. A lead hospital to be identified for each network to coordinate regional plans for hospitals in the network in concert with other laboratory service providers in the region,

3. A lead provider identified for community services in each region, to ensure that plans limit duplication and are provided in a coordinated way.

4. A Ministry planner/ facilitator assigned to each region to supervise/ facilitate planning and advise on the progress of planning, ie. whether the region has the potential to develop a plan collaboratively or whether another mechanism may be required (such as a competitive process). If the region does not appear in the Ministry's view to be making progress to finalize a plan, the process will be discontinued and providers directed as to their roles in the region.

5. Participation in planning will be directed by the MOHLTC (mandatory) for all providers.

Regional Planning Group to include:

- Lead hospital(s): academic and community
- Lead community laboratories (from a community advisory committee)
- Laboratory physician leads (from a physician advisory committee)
- MOHLTC representative(s) and facilitator
- DHCs

(Provincial Group to further recommend the structure and composition of this group)

MOHLTC Expectations:

Within 2 months:

- Planning group established: sub-groups as required for the progress to date in the region
- Baseline information confirmed, gaps or service problems that require special examination identified, review of services (Section 11 lists service components and elements for the regional plan; quality targets are in Schedule D of the RFP). Identify any barriers to achieving a regional plan. Review hospital allocations and services to identify whether additional review of any by Ministry financial staff is required.
- Identify any service expectations/ standards that may need to be revisited with the Ministry, based on the region's existing services.

Within 4 months:

- Identify service enhancements or efficiencies and plan for achieving service changes, and timelines
- Prepare a laboratory physician/ scientist human resources plan
- Principles for a HR plan if plans call for staffing changes in any facility

Within 5 months:

- Plan submitted to the MOHLTC for approval.
- 3rd party assessment of plan to ensure plan provides best value (quality and efficiency) for money: MOHLTC to appoint.

Criteria for Roll Out of Regional Plans:
The following criteria will be used to select regions to proceed first in the roll out of regional plans for all services:

- Stakeholder readiness as indicated by the extent of their planning to date
  - considerable progress made in the development of joint service plans between hospitals
  - consolidation of hospital services as a result of HSRC directions
  - partnerships/joint ventures between private and public service providers

- Ease of implementation
  - progress in hospital planning for consolidation of services
  - state of planning between various providers

- Demonstrated ability of service providers to work together
  - history of cooperation between sectors
  - planned and established networks
  - number of champions in a region

- Communication
  - Ability of reform champions in the region to send a positive message on the benefits of change
  - Public perception – DHCs on side

Funding/ Planning Models for discussion at the Provincial Group (based on discussions on May 11 and 12, 2000, to incorporate various options arising from the discussions). This has been developed to focus discussions on May 18 and 19 with a view to achieving general agreement.

Model One:

a. Central provincial envelope for all laboratory services; managed through a joint governance by the OAML, OHA and OMA, MOHLTC representation, i.e. Provincial Advisory Body

b. The allocation at its inception to be based on current hospital global allocations for laboratory services, the community laboratory services allocation and allocations for laboratory pilots currently underway in small communities.

c. Regional allocations from this to be identified based on current expenditures in hospitals and community laboratories. To ensure service continuity as reforms proceed the existing services within the region (and allocations associated with community services and hospital based services) will be retained through the regional planning phase (up to 6 months) until the regional plan and business case has been completed to justify shifts in funding from the community portion to hospitals or vice versa (shifts will occur if the business case identifies cost efficiencies, service changes that will benefit the public or quality enhancements).

d. Physician APPs/ physician service groups if implemented in regional plans will require a shift of funds (L-800 and hospital allocation for salaries and benefits)

Model Two:

a. No Provincial Advisory Body to address funding for the regions: arrangements for each region are with the Ministry of Health and Long-Term Care.

b. One envelope of funding for the region. MOHLTC allocates to each group of facilities (network) based on the regional plan and the role of that group/ laboratory in the plan.

c. Other features same as model one.

Model three:

a. The Region identifies a governance structure that provides for funding to be flowed and managed by a lead provider in the region.

b. Funding for all community and hospital based services to be managed by the entity, accountable to the Ministry of Health and Long-Term Care.

c. Physician APPs

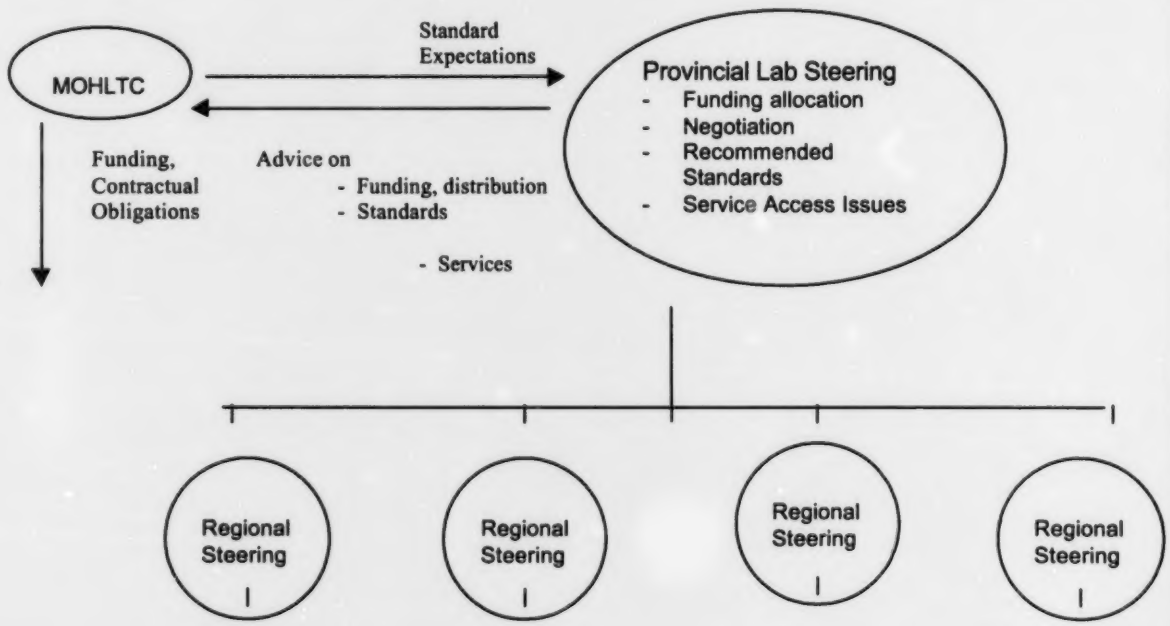
Accountability:

1. Contractual obligations will be in place between providers and the Ministry of Health and Long-Term Care, and between groups of providers to ensure no gaps in services.

2. Options for governance/ management of the system include:

Accountability/governance

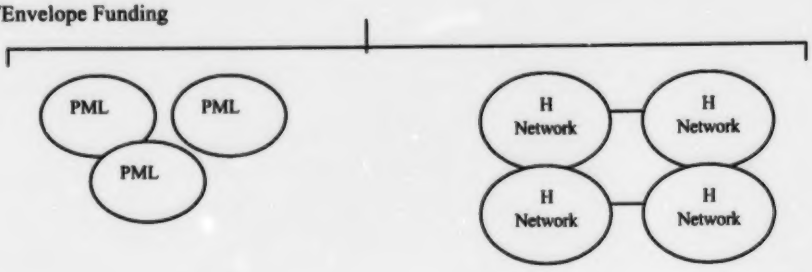
i. Provincial Structure



ii. Regional organization: Possible Models

Governance/Envelope Funding

1)



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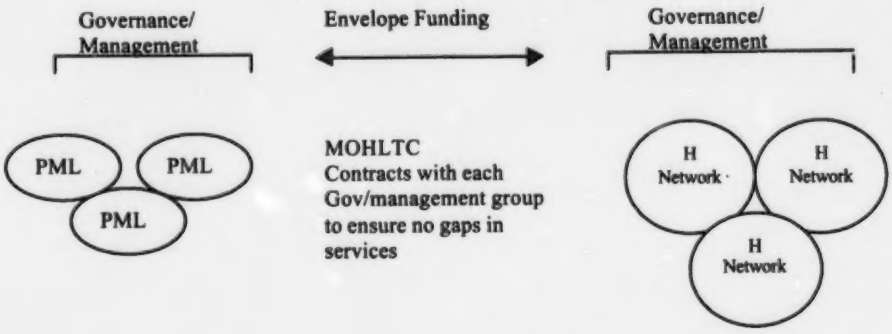

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